





City of Manassas Fire and Rescue System 9324 West Street, Suite 103 Manassas, VA 20110 Ph: 703-257-8458 Fax: 703-257-2403

Walk-In Patient Representative Form
PLEASE PROVIDE TWO FORMS OF IDENTIFICATION. ONE FORM MUST CONTAIN PHOTO

Relationship to patient: Patient Name: Patient Date of Birth: Patient Address:  Please check the reason for your visit: Obtain copy of invoice/statement: Other:  Drop off documentation:  Please specify what type of document:  Patient Representative Signature:  FOR EMS Billing Staff Only:  Type of Identification:  Driver's License  ID#  Issuing State:  Issuing State:	Date:				
Patient Name: Patient Date of Birth: Patient Address:  Please check the reason for your visit: Obtain copy of invoice/statement: Other:  Drop off documentation:  Please specify what type of document:  Patient Representative Signature:  FOR EMS Billing Staff Only:  Type of Identification:  Driver's License  ID#  Issuing State:  Issuing State:	Name:				
Patient Date of Birth: Patient Address:  Please check the reason for your visit: Obtain copy of invoice/statement:  Drop off documentation:  Please specify what type of document:  Patient Representative Signature:  FOR EMS Billing Staff Only:  Type of Identification:  Driver's License  ID#  Issuing State:	Relationship to patient:				
Patient Address:  Please check the reason for your visit: Obtain copy of invoice/statement: Obtain copy of invoice/statement: Other:  Drop off documentation:  Please specify what type of document:  Patient Representative Signature:  FOR EMS Billing Staff Only:  Type of Identification:  Driver's License  ID#  Issuing State:	Patient Name:				
Please check the reason for your visit: Obtain copy of invoice/statement: Other:  Drop off documentation:  Please specify what type of document:  Patient Representative Signature:  FOR EMS Billing Staff Only:  Type of Identification:  Driver's License  ID#  Issuing State:	Patient Date of Birth:				
Obtain copy of invoice/statement:  Drop off documentation:  Please specify what type of document:  Patient Representative Signature:  FOR EMS Billing Staff Only:  Type of Identification:  Driver's License  ID#  Issuing State:  Issuing State:	Patient Address:				
Drop off documentation:  Please specify what type of document:  Patient Representative Signature:  FOR EMS Billing Staff Only:  Type of Identification:  Driver's License  ID#  Issuing State:  ID#  Issuing State:	Please check the reason for your visit	t <b>:</b>			
Please specify what type of document:  Patient Representative Signature:  FOR EMS Billing Staff Only:  Type of Identification:  Driver's License  ID#  Issuing State:  ISSUING State:			Other:		
Patient Representative Signature:  FOR EMS Billing Staff Only:  Type of Identification:  Driver's License  ID#  Issuing State:  ISsuing State:	Drop off documentation:				
FOR EMS Billing Staff Only:  Type of Identification:  Driver's License  ID#  Issuing State:  ISsuing State:	Please specify what type of document :				
Type of Identification:    Driver's License	Patient Representative Signature:				
ID# Issuing State:  ID# Issuing State:  ID# Issuing State:	FOR EMS Billing Staff Only:			+ + + -	
Driver's License  ID#  Issuing State:	Type of Identification:				
	Driver's License	ID#		Issuing State:	
State ID	-	ID#		Issuing State:	
<del>                                     </del>	State ID				
If other, please specify:	If other, please specify:				
Name of EMS Billing Staff: Date:	Name of EMS Billing Staff:			Date:	